TITLE 10: CALIFORNIA CODE OF REGULATIONS

CHAPTER 5.5 MAJOR RISK MEDICAL INSURANCE PROGRAM

ARTICLE 1. Definitions

2698.100. Definitions

For the purposes of this part:

(a) "Appellant" means an applicant or subscriber who has filed an appeal with the program.

(b) "Applicant" means an individual who has filed a complete application for major risk medical coverage and paid the initial subscriber contribution.

(c) "Authorized Representative" means any person or entity who has been designated, in writing, by the appellant to act on his/her behalf.

(d) "Board" means the Managed Risk Medical Insurance Board.

(e) "Coverage" means the payment for medically necessary services provided by institutional and professional providers.

(f) "Dependent" means a subscriber's spouse and any unmarried child, who is an adopted child, a stepchild, or a recognized natural child, who lives with the subscriber in a regular parent-child relationship. A child attains the status of "dependent" at birth or upon legal adoption. A child shall be considered to be adopted upon the subscriber receiving physical custody of the child to be adopted. A stepchild attains the status of "dependent" upon the subscriber's marriage to the natural or adopted stepchild's parent. "Dependent" includes any unmarried child who is economically dependent upon the applicant, where there exists a parent-child relationship with the applicant. He or she ceases to be a "dependent" upon marriage, or attainment of age 23, whichever first occurs; except that an unmarried child who at the time of attaining age 23 is incapable of self-support because of physical or mental disability which existed continuously from a date prior to attainment of age 23 continues in dependent status until termination of such incapacity. For the purpose of Section 2698.205, a dependent's status shall not change upon death of the subscriber or upon the subscriber being disenrolled due to becoming eligible for Medicare Part A and Part B.

(g) "Disenroll" means termination from coverage by the program.

(h) "Eligible" means the applicant is qualified to be enrolled along with dependents in a participating health plan.

(i) "Enroll" means to accept an applicant as a subscriber by notifying a participating health plan to accept the applicant and dependents, if any, for coverage.

(j) "Executive Director" means the Executive Director for the Board.

(k) "Fee-for-service plan" means either of the following:

(1) Service benefit plans under which retrospective payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services rendered to subscribers.

(2) Indemnity benefit plans under which a carrier agrees to pay retrospectively certain sums of money, not in excess of actual expenses incurred, for health services.

(l) "Health maintenance organization" means either of the following:

(1) Comprehensive group-practice prepayment plans which offer benefits, in whole or in substantial part, on a prepaid basis, with professional services thereunder provided by physicians or other providers of health services practicing as a group in a common center or centers. This group shall include physicians representing at least three major medical specialties who receive all or a substantial part of their professional income from the prepaid funds.

(2) Individual practice prepayment plans or network model prepayment plans which offer health services in whole or in part on a prepaid basis, with professional services thereunder provided by individual physicians or groups of physicians or other providers of health services who agree to accept the payments provided by the plans as full payment for covered services rendered by them.

(m) "Health plan" means a private insurer holding a valid outstanding certificate of authority from the Insurance Commissioner, a nonprofit hospital service plan qualifying under Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code, a nonprofit membership corporation lawfully operating under the Nonprofit Corporation Law (Division 2 (commencing with Section 5000) of the Corporations Code), or a health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code, which is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service agreements, or membership contracts, in consideration of premiums or other periodic charges payable to it.

(n) "Medicare" means the Health Insurance For The Aged provided under Title XVIII of the Social Security Act; "Part A" means Hospital Insurance as defined in Title

XVIII of the Social Security Act; and "Part B" means Medical Insurance as defined in Title XVIII of the Social Security Act.

(o) "Participating health plan" means a health plan which has a contract with the program to administer major risk medical coverage for program subscribers. Participating health plans are categorized as either fee-for-service plans or health maintenance organizations as defined in Section 2698.100 (l) or (m) respectively.

(p) "Pre-existing condition" means any condition for which medical advice, diagnosis, care, or treatment was recommended or received during a six month period immediately preceding the effective date of coverage.

(q) "Post-enrollment waiting period" means that period of time between the date of enrollment and the date coverage begins.

(r) "Program" means the California Major Risk Medical Insurance Program.

(s) “Qualifying prior coverage” means:

(1) Any individual or group policy, contract or program, that is written or administered by a disability insurance company, nonprofit hospital service plan, health care service plan, fraternal benefits society, selfinsured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issues as a supplement to liability insurance, insurance arising out of a workers’ compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The Medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere of medical, hospital and surgical care

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(t) “Resident” means a person who is present in California with intent to remain present except when absent for transitory or temporary purposes. However, a person who is absent from the state for a consecutive period greater than 210 days shall not be considered a resident.

(u) “Standard average individual rate” means that rate a participating health plan estimates it would charge the general public for individual, non-group coverage for the benefits described in the program contract with the participating health plan.

(v) "Subscriber" means an individual who is eligible for and receives major risk medical coverage through the program. "Subscriber" does not include an individual receiving major risk medical coverage through the program as an enrolled dependent of a subscriber. An individual who is enrolled but not yet receiving coverage due to a post-enrollment waiting period is considered a subscriber.

(w) "Subscriber contribution" means the amount paid by a subscriber on a periodic basis to the program for coverage for a subscriber and enrolled dependents, if any.

(x) Tenses, and Number. The present tense includes the past and future, and the future the present; the singular includes the plural and the plural the singular.

(y) "Time". Whenever in this chapter a time is stated in which an act is to be done, the time is computed by excluding the first day and including the last day. If the last day is a holiday it is also excluded.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code.
Reference: Sections 12705, 12711, 12712, 12725 and 12730, Insurance Code.

Article 2. Eligibility, Application, and Enrollment

2698.200. Basis of Eligibility.

(a) All eligibility requirements contained herein shall be applied without regard to sex, race, creed, color, sexual orientation, health status, national origin, occupation, or occupational history of the individual applying for the program.

(b) To be eligible for the program, an applicant shall meet the requirements of either (1) or (2):

(1) Meet all of the following requirements:

(A) Be a resident of the State of California; and

(B) Not be eligible for Part A and Part B of Medicare, except those applicants on Medicare solely because of end-stage renal disease; and

(C) Not be eligible to purchase any health insurance for continuation of benefits under the provisions of 29 US Code 1161 and following sections; and

(D) Be unable to secure adequate private coverage. An individual shall be deemed unable to secure adequate private health coverage if the individual within the previous 12 months:

1. Has been denied individual coverage; or

2. Has been involuntarily terminated from health insurance coverage for reasons other than nonpayment of premium or fraud; or

3. Has been offered an individual, not a group, health insurance premium rate in excess of the subscriber rate for the individual's first choice participating health plan.

(2) Be a dependent of an individual meeting the requirements of (b)(1) of this section.

(c) To remain eligible an individual shall:

(1) Remain a resident of California; and

(2) Not become eligible for Part A and Part B of Medicare, except those applicants who become eligible for Medicare solely because of end-stage renal disease.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code.
Reference: Section12711, 12725, and 12733, Insurance Code.

2698.201. Application

(a) The Board shall establish an application review process which assures timely action on applications. The program shall complete the application review process within 30 calendar days of receipt of application and payment of the initial subscriber contribution.

(b) To apply for the program an individual shall submit:

(1) all information, documentation, and declarations necessary to determine program eligibility as set forth in subsection (e) of this section, and

(2) a check or money order for an amount equal to the initial subscriber contribution for the individual's first choice participating health plan.

(c) The individual or the individual's parent, conservator, or guardian shall sign and date a declaration stating that the information given is true and accurate.

(d) An incomplete application shall be returned to the individual and shall not be processed.

(e) (1) The application, entitled California Major Risk Medical Insurance Program Enrollment Application (July, 1996), shall contain the following:

(A) The individual's full name,

(B) The individual's current living address including house or unit number, street, city, county, state, and zip code,

(C) The individual's date of birth,

(D) The individual's sex,

(E) The individual's social security number (provision of the Social Security Number is not mandatory),

(F) If dependents are to be included in the coverage, the full names, dates of birth, sex, social security numbers (not mandatory), and relationship of the dependents to be covered.

(G) The address to which the bills for the subscriber's contribution are to be sent,

(H) Proof of rejection within 12 months of the date of application for health insurance coverage for reasons other than fraud or nonpayment of premium. The proof shall include a letter or other formal written communication from a health plan, documenting one or more of the following:

1. Having been denied health insurance coverage as an individual.

2. Having been involuntarily terminated from health insurance coverage.

3. Having been offered an individual, not a group, health insurance premium rate in excess of the subscriber rate for the individual's first choice participating health plan.

(I) A declaration that the individual is not eligible for Part A and Part B of Medicare, in accordance with subsection 2698.200(b)(1)(B).

(J) A declaration that the individual is a resident of the state of California,

(K) A declaration that the individual will abide by the rules of participation, utilization review process, and dispute resolution process of any participating health plan in which the individual is enrolled,

(L) A declaration that the individual is not, to the individual's knowledge, being excluded from a group for the purpose of being made eligible for the program,

(M) A declaration that the individual has reviewed the benefits offered by the participating health plans and the subscriber contribution rates,

(N) A declaration that the individual understands and will follow the rules and regulations of the program,

(O) Name and address of the individual's primary employer, if employed,

(P) An indication of the individual's first choice and second choice participating health plans, and

(Q) If an individual is not currently eligible for the program, but anticipates becoming eligible, the individual shall explain and document the reason or reasons, and provide the date on which eligibility will occur. If the individual is currently enrolled as a dependent of a subscriber but is independently eligible for the program, the individual shall explain and document the reasons for which independent enrollment is sought.

(2) Social Security number and other personal information are needed for identification and administrative purposes.

(f) In order for the program to determine that a pre-existing condition exclusion for a specific condition or a post enrollment waiting period should be waived, or partially waived, the individual must provide one of the following:

(1) Documentation that the individual had qualifying prior coverage, or

(2) Documentation that the individual has been covered by a similar plan sponsored by another state before becoming a California resident.

(g) Applicants may make application at any time. An applicant shall not be enrolled nor shall the applicant be placed on a waiting list until the applicant has fulfilled all of the requirements for eligibility. Once the requirements for eligibility are fulfilled, applicants shall be enrolled or put on waiting lists in order of the date of receipt of the application.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code.
Reference: Sections 12711, 12725 and 12728, Insurance Code.

2698.202 Determination of Eligibility

(a) Upon receipt of a complete application the program shall determine applicants' eligibility based upon the criteria specified in Section 2698.200.

(b) Applicants determined ineligible shall be notified in writing by the program, except as in (1) below. The notice shall include the reason for the determination of ineligibility and an explanation of the appeal process. The applicants' initial subscriber contributions shall be refunded.

(1) If an applicant is determined to be currently ineligible, but the applicant has documented pursuant to Section 2698.201(e)(1)(Q) that he/she will become eligible, the applicant shall be notified that the application will be held until the eligibility date specified, and on that date the applicant will be determined eligible. The applicant's initial subscriber contribution shall not be refunded.

(c) Applicants determined eligible shall be either enrolled or placed on a waiting list and shall be notified of their status.

(d) Applicants who are not currently enrolled as dependents, who are eligible to become program subscribers shall be enrolled in accordance with Section 2698.203, unless one of the following circumstances exist:

(1) Both the first and second choice participating health plans of the applicant are currently serving the maximum number of subscribers which they have contracted with the program to serve.

(2) A program funding shortfall has been projected.

(e) Applicants who are currently enrolled as dependents, who are determined eligible to become program subscribers shall be enrolled in accordance with Section 2698.203.

(f) When the circumstances in (d)(1) or (2) exist, applicants shall be placed on a waiting list in the order in which their completed applications were received by the program. When a vacancy occurs or funds become available, whichever is applicable, applicants shall be enrolled in accordance with Section 2698.203 based upon the order in which they appear on the program's waiting list.

(g) The program shall refund the initial subscriber contribution to all applicants who have been on the program's waiting list for more than 60 days from the date their completed applications were received. Such applicants shall, within 30 days of notification by the program that enrollment is possible, pay the initial subscriber contribution and notify the program of any additional dependents to be enrolled. Failure to comply with this 30-day payment requirement shall result in program ineligibility for a period of one year.

(h) The program shall complete the enrollment of an applicant on the waiting list within 15 calendar days of receipt of payment of the initial subscriber contribution that has met the requirements of (g) of this section.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code.
Reference: Sections 12711, 12725 and 12728, Insurance Code.

2698.203. Enrollment.

(a) Providing neither of the circumstances specified in Section 2698.202 (d) exists, applicants determined eligible for the program shall be enrolled in their:

(1) First choice participating health plan, unless that plan is currently serving the number of subscribers which it has contracted with the program to serve.

(2) Second choice participating health plan when the first choice plan is currently serving the number of subscribers which it has contracted with the program to serve.

(b) If a subscriber applied to have dependents covered, dependents shall also be enrolled in the subscriber's participating health plan.

(c) The date on which the coverage shall begin, subject to the provisions of Section 2698.303, shall be the first day of the month following enrollment.

(d) An applicant shall be notified in writing by the program of enrollment with a participating health plan, the beginning date of coverage by the participating health plan, and of any pre-existing condition exclusion period or post enrollment waiting period. The notice shall caution the subscriber about discontinuing any existing coverage until full coverage by the participating health plan is begun.

NOTE: Authority cited: Sections 12711, 12712 and 12712.5, Insurance Code.
Reference: Sections 12711, 12725 and 12728, Insurance Code.

2698.204. Disenrollment

(a) A subscriber and/or enrolled dependents, if any, shall be disenrolled from the program and from the program's participating health plan when any of the following occur:

(1) The subscriber so requests.

(2) The subscriber fails to make subscriber contributions in accordance with Section 2698.403.

(3) The subscriber and/or enrolled dependent becomes ineligible because of:

(A) The subscriber's failure to meet the residency requirement; or

(B) The subscriber and/or enrolled dependent becoming eligible for Part A and Part B of Medicare, except subscribers or enrolled dependents on Medicare solely because of end-stage renal disease. An enrolled dependent of a subscriber who becomes eligible for Part A and Part B of Medicare may remain eligible for the program pursuant to Section 2698.205.

(4) The subscriber or an enrolled dependent has committed an act of fraud to circumvent the statutes or regulations of the program.

(5) The dependent ceases to be a dependent as defined in Section 2698.100(f). This shall not affect the enrollment status of a dependent who was enrolled as a dependent who became an independent subscriber.

(b) A subscriber shall be notified by the program in writing of the disenrollment of the subscriber and enrolled dependents, if any, from the program and the reason for the disenrollment, which shall take effect thirty (30) days following the date of the notice. In cases of disenrollment because of nonpayment of subscriber contribution the effective date of disenrollment will be retroactive to the last day for which the subscriber contribution was paid.

(c) If disenrolled for any reason, a subscriber and enrolled dependents, if any, shall not be eligible for enrollment in the program for one year from the date of disenrollment, unless the enrolled dependents have continued eligibility pursuant to Section 2698.205.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code:
Reference: Sections 12711, 12733 and 12735, Insurance Code.

2698.205. Continuation of Benefits.

If a subscriber is disenrolled because of death or eligibility for Medicare Part A and Part B, enrolled dependents shall be eligible to continue coverage in the program from a participating health plan for as long as the enrolled dependent would have been eligible had the subscriber remained enrolled.

NOTE: Authority cited: Sections 12711, 12712 and 12712.5, Insurance Code.
Reference: Section 12730, Insurance Code.

2698.206. Change in Coverage

(a) A subscriber wishing to enroll additional dependents shall notify the program of the full names, dates of birth, sex, social security numbers (not mandatory), and relationship of the dependents to be enrolled. Social Security number and other personal information are needed for identification and administrative purposes. Coverage for additional dependents shall be subject to the following:

(1) Coverage for newborn or adopted children that are dependents shall begin upon birth or adoption of the child. Coverage for stepchildren that are dependents shall begin upon marriage by a subscriber to the stepchild's parent. Subscribers shall notify the program of the birth, adoption, or the addition of a stepchild within thirty (30) days to continue coverage of the newborn, adopted child, or stepchild. A child shall be considered to be adopted upon the subscriber receiving physical custody of the child to be adopted.

(2) Coverage for all other dependents shall begin within 90 days of receipt of the notification to the program from the subscriber.

(3) Subscribers shall be notified by the program of the beginning date of coverage for enrolled dependents.

(b) A subscriber wishing to disenroll dependents shall notify the program of the full names, dates of birth, sex, social security numbers, and relationship of the dependents to be disenrolled. Disenrollment of dependents shall be subject to the following:

(1) The program shall inform the participating health plan within fifteen (15) days of the date of the receipt of the notification to the program by the subscriber.

(2) The participating health plan shall disenroll the dependents within fifteen (15) days of being informed by the program of the request for disenrollment.

(3) The subscriber's contribution shall be adjusted, if applicable, as of the date of disenrollment by program.

(4) The program shall notify the subscriber of the date of disenrollment.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code.
Reference: Section 12729, Insurance Code.

2698.207 Transfer of Enrollment

(a) A subscriber and enrolled dependents, if any, shall be transferred from one participating health plan to another if any of the following occurs:

(1) The subscriber so requests, in writing, during an open enrollment period established by the Board. The program shall inform each subscriber of each open enrollment period.

(2) The subscriber so requests, in writing, because the subscriber has moved and no longer resides in an area served by the participating health plan in which the subscriber is enrolled, and there is at least one participating health plan serving the area in which the subscriber now resides that is accepting new enrollees.

(3) The subscriber or the participating health plan so requests, in writing, because of failure to establish a satisfactory subscriber-plan relationship and the executive director determines that the transfer is in the best interests of the program, and there is at least one participating health plan serving the area in which the subscriber resides that is accepting new enrollees.

(b) Subscribers who transfer enrollment pursuant to this section shall not be subject to pre-existing condition exclusions or post enrollment waiting periods as specified in Section 2698.303.

(c) Transfer of enrollment pursuant to (a)(1) shall take effect 60 days after the termination of an open enrollment period. Transfer of enrollment pursuant to (a)(2) or (a)(3) shall take effect within 35 days of approval of the request.

(d) Subscribers and participating health plans shall be notified in writing of any transfer of enrollment.

NOTE: Authority cited: Sections 12711, 12712 and 12712.5, Insurance Code.
Reference: Section 12731, Insurance Code.

2698.208. Payment to Insurance Agents and Brokers

(a) If authorized by the board, the program shall pay an insurance agent as defined in Section 31 of the Insurance Code or broker as defined in Section 33 of the Insurance Code for assisting an individual in completing the application form, if the following conditions are met:

(1) The individual is enrolled as a result of the application;

(2) The agent or broker requests such payment in writing; and

(3) Such request accompanies the application and includes the name, license number, and address of the agent or broker.

(b) The amount of such payment shall be $50.00.

NOTE: Authority cited: Sections 12711, 12712 and 12712.5, Insurance Code.
Reference: Sections 12711 and 12711.5, Insurance Code.

Article 3. Minimum Scope of Benefits

2698.300 Deductible and Copayment

(a) Each participating health plan shall be permitted to require copayments and deductibles for benefits provided to a subscriber and enrolled dependents subject to the following limits:

(1) The copayment shall not exceed 25 percent of the cost of covered services. However, health plans not utilizing a deductible may be authorized to charge an office visit copayment of up to twenty-five dollars ($25).

(2) The deductible shall not exceed $500 annually for a household, which consists of a subscriber and any enrolled dependents.

(3) The sum of the copayment and deductible shall not exceed $2,500 annually for a subscriber or $4,000 annually for a subscriber and enrolled dependents.

(b) When a subscriber's selected participating health plan is a plan that has contracts with certain listed providers from whom care is to be received for non-emergency conditions, and there are additional subscriber payments to providers other than those listed, such additional subscriber payments shall not be subject to the limits of this section.

NOTE: Authority cited: Sections 12711 and 12712 Insurance Code.
Reference: Section 12718, Insurance Code

2698.301. Minimum Scope of Benefits

(a) The basic minimum scope of benefits offered by participating health plans to subscribers and enrolled dependents must comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975 including amendments as well as its applicable regulations, and shall include all of the benefits and services listed in this section. Except as required by the applicable statute and regulations, no other benefits shall be permitted to be offered by a participating health plan unless specifically provided for in the program contract with the participating health plan. The basic minimum scope of benefits shall be as follows:

(1) Hospital inpatient care in a hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code, including all of the following benefits and services:

(A) Semi-private room, including meals and general nursing services; and private room and special diets when prescribed as medically necessary.

(B) Hospital services, including use of operating room and related facilities, intensive care unit and services, labor and delivery room, and anesthesia.

(C) Drugs, medications, and parenteral solutions administered while an inpatient.

(D) Dressing, casts, equipment, oxygen services, and radiation therapy.

(E) Respiratory and physical therapy.

(F) Diagnostic laboratory and x-ray services.

(G) Special duty nursing as medically necessary.

(H) Administration of blood and blood products.

(I) Other diagnostic, therapeutic or rehabilitative services (including occupational, physical and speech therapy) as appropriate.

(J) Medically necessary inpatient alcohol and substance abuse.

(K) General anesthesia and associated facility charges in connection with dental procedures rendered in a hospital, when the clinical status or underlying medical condition of a subscriber requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital. This benefit is only available to subscribers under seven years of age; the developmentally disabled, regardless of age; and subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.

Nothing in this section shall require a participating health plan to cover any charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist.

(2) Medical and surgical services, provided on an outpatient basis whenever medically appropriate, including all of the following:

(A) Physician services including consultations, referrals, office and hospital visits and surgical services performed by a physician and surgeon.

(B) Diagnostic laboratory services, diagnostic and therapeutic radiological services and other diagnostic services that shall include but not be limited to nuclear medicine, ultrasound, electrocardiography and electroencephalography.

(C) Dressings, casts and use of castroom, anesthesia, and oxygen services when medically necessary.

(D) Blood, blood derivatives and their administration.

(E) Radiation therapy and chemotherapy, of proven benefit.

(F) Comprehensive preventive care of children, 16 years of age or younger which is consistent with the Recommendations for Preventive Pediatric Health Care as adopted by the American Academy of Pediatrics in September of 1987, and the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians. Comprehensive preventive care services shall in include periodic health evaluations, immunizations and laboratory services in connection with periodic health evaluations.

(G) General anesthesia and associated facility charges in connection with dental procedures rendered in a surgery center setting, when the clinical status or underlying medical condition of a subscriber requires dental procedures that ordinarily would not require general anesthesia to be rendered in a surgery center setting. This benefit is only available to subscribers under seven years of age; the developmentally disabled, regardless of age; and subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.

Nothing in this section shall require a participating health plan to cover any charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist.

(H) Nothing in this section shall preclude the direct reimbursement of physician assistants, nurse practitioners or other advanced practice nurses who provide covered services within their scope of licensure.

(3) Family planning services including a variety of prescriptive contraceptive methods approved by the federal Food and Drug Administration, and reproductive sterilization.

(4) Comprehensive maternity and perinatal care, including the services of a physician and surgeon, certified nurse midwife or nurse practitioner, and all necessary hospital services, including services related to complications of pregnancy, are covered services. Nothing in this section shall preclude the direct reimbursement of

nurse practitioners or other advanced practice nurses in providing covered services.

(5) Emergency care including out-of-area coverage. Emergency ambulance transportation including transportation provided through the '911" emergency response system.

(6) Reconstructive Surgery: Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following;

(A) improve function.

(B) create a normal appearance to the extent possible.

Includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

(7) Prescription drugs, limited to drugs approved by the federal Food and Drug Administration, generic equivalents approved as substitutable by the federal Food and Drug Administration, or drugs approved by the federal Food and Drug Administration as Treatment Investigational New Drugs. Also includes insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin, blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent and gestational diabetes.

(8) Mental Health benefits are covered as follows:

(A) For severe mental illnesses, including serious emotional disturbances of children, inpatient services, outpatient services, partial hospitalization services and prescription medications. Severe mental illnesses include schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.

(B) Except as specified in Subsection (A) above, mental health benefits are limited to the following:

1. Inpatient care for a period of 10 days in each calendar year.

2. 15 outpatient visits in each calendar year.

(9) Medical rehabilitation and the services of occupational therapists, physical therapists, and speech therapists as appropriate on an outpatient basis.

(10) Durable medical equipment, including prosthetics to restore and achieve symmetry incident to a mastectomy and to restore a method of speaking incident to a laryngectomy. Covered services also include blood glucose monitors and blood glucose monitors for the visually impaired for insulin dependent, non-insulin dependent and gestational diabetes; insulin pumps and all related necessary supplies; visual aids to assist the visually impaired with proper dosing of insulin and podiatric devices to prevent or treat diabetes complications.

(11) Home Health Services: Health services provided at the home by health care personnel. Includes visits by Registered Nurses, Licensed Vocational Nurses, and home health aides; physical, occupational and speech therapy; and respiratory therapy when prescribed by a licensed practitioner acting within the scope of his or her licensure.

(12) The following human organ transplants: corneal, human heart, heart-lung, liver, bone-marrow and kidney transplantation. Transplants other than corneal shall be subject to the following restrictions:

(A) Pre-operative evaluation, surgery, and follow-up care shall be provided at centers that have been designated by the participating health plan as having documented skills, resources, commitment and record of favorable outcomes to qualify the centers to provide such care.

(B) Patients shall be selected by the patient-selection committee of the designated centers and subject to prior authorization.

(C) Only one transplantation per organ-type per patient is covered. Replacement of a rejected organ will not be covered.

(D) Only anti-rejection drugs, biological products, and other procedures that have been established as safe and effective, and no longer investigational, are covered.

(13) Hospice services pursuant to Health and Safety Code Section 1368.2.

(14) This part shall not be construed to prohibit a plan's ability to impose cost-control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing benefits in alternative settings or using alternative methods.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code.
Reference: Sections 12711 and 12712, Insurance Code.

2698.302. Excluded Benefits

(a) Plans offered under this program shall exclude the following benefits unless specifically provided for in the program contract with the participating health plan:

(1) Services that are not medically necessary. "Medically necessary" as applied to the diagnosis or treatment of illness is an article or service that is not investigational and is necessary because:

(A) It is appropriate and is provided in accordance with accepted medical standards in the state of California, and could not be omitted without adversely affecting the patient's condition or the quality of medical care rendered; and

(B) As to inpatient care, it could not have been provided in a physician's office, in the outpatient department of a hospital, or in a lesser facility without adversely affecting the patient's condition or the quality of medical care rendered; and

(C) If the proposed article or service is not commonly used, its application or proposed application has been preceded by a thorough review and application of conventional therapies; and

(D) The service or article has been demonstrated to be of significantly greater therapeutic value than other, less expensive, services or articles.

(2) Any services which are received prior to the enrollee's effective date of coverage.

(3) Custodial, domiciliary care, or rest cures for which facilities of a general acute care hospital are not medically required. Custodial care is care that does not require the regular services of trained medical or health professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered.

(4) Personal or comfort items, or a private room in a hospital unless medically necessary.

(5) Emergency facility services for nonemergency conditions.

(6) Those medical, surgical (including implants), or other health care procedures, services, drugs, or devices which are either:

(A) Services, products, drugs or devices which are experimental or investigational or which are not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question.

(B) Outmoded or not efficacious.

(7) Transportation except as specified in Section 2698.301(a)(5).

(8) Implants, except cardiac pacemakers, intraocular lenses, screws, nuts, bolts, bands, nails, plates, and pins used for the fixation of fractures or osteotomies and artificial knees and hips; and except as specified in Section 2698.301(a)(6).

(9) Sex change operations, investigation of or treatment for infertility, reversal of sterilization, and conception by artificial means.

(10) Eyeglasses, contact lenses (except the first intraocular lens following cataract surgery), routine eye examinations, including eye refractions, except when provided as part of a routine examination under "preventive care for minors," hearing aids, orthopedic shoes, orthodontic appliances, and routine foot care are excluded.

(11) Long-term care benefits including home care, skilled nursing care, respite care, and hospice care are excluded except as a participating health plan shall determine they are less costly alternatives to the basic minimum benefits.

(12) Dental services and services for temporomandibular joint problems are excluded, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that the repair commences within 90 days of the accidental injury or as soon thereafter as is medically feasible.

This language shall not be construed to exclude surgical procedures for any condition directly affecting the upper or lower jawbone, or associated bone joints.

(13) Treatment of chemical dependency except as specified in Section (a)(1)(J).

(14) Cosmetic surgery, including treatment for complications of cosmetic surgery, except as specifically provided in Section 2698.301(a)(6).

(15) Conditions resulting from acts of war (declared or not) if the exclusion is approved by specific order of the Director of the Department of Managed Health Care.

(b) Benefits which exceed $75,000 in a calendar year under the program for a subscriber or a subscriber's enrolled dependent shall be excluded.

(c) Benefits which exceed $750,000 in a lifetime under the program for a subscriber or a subscriber's enrolled dependent shall be excluded. Benefits received prior to January 1, 1999 shall be counted towards the $750,000 lifetime maximum.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code.
Reference: Sections 12711 and 12712, Insurance Code.

2698.303. Pre-Existing Conditions Exclusion and Postenrollment Waiting Period.

(a) Unless a waiver is granted pursuant to subsection (c), subscribers and enrolled dependents who enroll in a health maintenance organization participating health plan shall be subject to a postenrollment waiting period. The postenrollment waiting period shall apply to all subscribers and enrolled dependents. Subscribers shall not be required to pay subscriber contributions during the waiting period. The postenrollment waiting period shall be 90 days unless reduced pursuant to subsection (c).

(b) Unless a waiver is granted pursuant to subsection (c), subscribers and enrolled dependents who enroll in a fee-for-service participating health plan shall be subject to a pre-existing condition exclusion period. During the preexisting condition exclusion period no benefits or services related to a preexisting condition shall be covered. Subscribers shall be required to pay subscriber contributions during the pre-existing condition exclusion period. The pre-existing condition exclusion period shall be 90 days unless reduced pursuant to subsection (c).

(c) Waivers or partial waivers to the postenrollment waiting period or preexisting condition exclusion period shall be granted for each individual subscriber or enrolled dependent providing any of the following criteria are met:

(1) If the subscriber or enrolled dependent had qualifying prior coverage, such coverage was terminated and the subscriber applies for eligibility in the program within 31 days of the termination, then the subscriber or enrolled dependent shall be granted a partial waiver. The post-enrollment waiting period or pre-existing condition exclusion period shall be waived for a period equal to the period of time the subscriber or enrolled dependent was enrolled in qualifying prior coverage up to a maximum of 90 days.

(2) The subscriber who had previously received coverage under a similar program in another state within the last 12 months, shall be granted a full waiver.

(3) A child dependent who enrolled pursuant to Section 2698.206(a) shall be granted a full waiver.

(4) The subscriber who was on the program waiting list in accordance with Section 2698.202 for 180 days or longer shall be granted a full waiver. A full waiver shall also be granted for any dependents enrolled at the same time as the subscriber.

(d) The program shall fully explain to applicants the type of health care coverage offered by each participating health plan, including the applicable waiting/exclusion periods specified in this section.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code.
Reference: Section 12726, Insurance Code.

Article 4. Risk Categories and Subscriber Contributions

2698.400. Risk Categories

(a) The risk categories on which the program and subscriber contributions are to be determined shall be the following:

(1) Six (6) geographic regions:

(A) Area 1 shall include the counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yuba, and Yolo.

(B) Area 2 shall include the counties of Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

(C) Area 3 shall include the counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara.

(D) Area 4 shall include the counties of Orange, Santa Barbara, and Ventura.

(E) Area 5 shall include the county of Los Angeles.

(F) Area 6 shall include the counties of Riverside, San Bernardino, and San Diego.

(2) Twelve (12) age groups:

(A) Under 15 years of age;

(B) 15-29 years of age;

(C) 30-34 years of age;

(D) 35-39 years of age;

(E) 40-44 years of age;

(F) 45-49 years of age;

(G) 50-54 years of age;

(H) 55-59 years of age;

(I) 60-64 years of age;

(J) 65-69 years of age;

(K) 70-74 years of age; and

(L) 75 years of age and over.

(b) No other risk categories shall be allowed for the purpose of this program.

NOTE: Authority cited: Sections 12711, 12712 and 12712.5, Insurance Code.
Reference: Section 12736, Insurance Code.

2698.401. Determination of Subscriber Contribution

(a) Each participating health plan shall provide an annual estimate of the standard average individual rate for the minimum benefits provided for in the contract with the participating health plan for each risk category specified in Section 2698.400. Without applying risk categories to dependents, each participating health plan shall also provide an estimate of the standard average rate for covering an individual in each risk category and the individual's dependents as follows:

(1) An individual and one dependent; and

(2) An individual and two or more dependents.

(b) For those participating health plans which have been offered through the program for two or more years, the Board shall calculate a loss ratio for each participating health plan for the prior calendar year. The loss ratio shall be calculated using 125 percent of the estimated rates provided by the participating plan as the denominator, and the sum of all medical costs for subscribers and dependents enrolled in the plan and all administration fees and risk payments to the plan as the numerator.

(c) For those participating health plans which have been offered through the program for two or more years, the Board shall calculate a percentage average subsidy amount per subscriber dollar contributed for each participating health plan for the prior calendar year by subtracting 100 percent from the program loss ratio percentage.

(d) The Board shall calculate the program loss ratio for the prior calendar year in the following manner:

(1) Participating health plans with an average monthly number of enrollees of fewer than 1,000 in the prior calendar year shall be excluded from the calculation.

(2) If a participating health plan's loss ratio is less than 100 percent it shall be deemed to be 100 percent for purposes of the calculation.

(3) The weighted average of the participating health plans' loss ratios is the program loss ratio.

(e) The Board shall calculate the program average subsidy for the prior calendar year by subtracting 100 percent from the program loss ratio percentage.

(f) For each participating health plan with an average subsidy percentage amount higher than the program average subsidy percentage, that difference shall be called the excess subsidy.

(g) The Board shall determine the subscriber contribution for each participating health plan that did not have an excess subsidy in the prior calendar year by multiplying the estimated rates provided by the participating health plan by 125 percent.

(h) The Board shall determine the base subscriber contribution for each participating health plan that did have an excess subsidy in the prior calendar year by multiplying the estimated rates provided by the participating health plan by an additional 25 percent and then adding the excess subsidy amount. However, the actual subscriber contribution shall be subject to the following limitations:

(1) No subscriber contribution will be more than 10 percent above 125 percent of the estimated rates provided by the participating plan. (See Title 10, Section 2698.100(u).)

(2) If all participating health plans available in a county have an excess subsidy amount, the subscriber contribution for the plan with the lowest excess subsidy amount will not include the excess subsidy amount.

(i) Subscriber contribution for participating health plans joining the program after January 1, 1997, shall be established at 125 percent of the estimated rates provided by the participating plan for the first two benefit years the plan participates in the program. (See Title 10, Section 2698.100(u).)

(j) Subscriber contribution shall be adjusted annually in accordance with this section.

(k) Subscribers shall be informed by the program of the annually adjusted subscriber contribution at least one month prior to the effective date of the rate charge.

NOTE: Authority cited: Sections 12711 and12712 Insurance Code.
Reference: Section 12713, 12736, 12737 and 12738, Insurance Code

2698.403. Subscriber Contribution Payments

Subscriber contribution payment procedures for subscribers and any dependents shall be as follows:

(a) Each month the program shall determine the amount of the subscriber contribution in accordance with Sections 2698.400 and 2698.401 and notify the subscriber of the subscriber contribution amount due to the program and the due date. The program shall send the notice at least 30 calendar days in advance of the due date.

(b) A subscriber shall submit the subscriber contribution to the program each month so that it is received no later than the first of each month for that month of coverage.

(c) The subscribers obligation to submit the subscriber contribution amount required by subsection (b) above is not contingent upon receipt of the notice specified in subsection (a). If the subscriber does not receive the notice specified in subsection (a) above, the subscriber shall make a good faith effort to determine the amount of the subscriber contribution and shall submit a payment of that amount by the due date.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code.
Reference: Section 12737, Insurance Code

2698.405. Overdue Payments

(a) A subscriber whose subscriber contribution is not paid in full for any reason by the due date shall be considered to be overdue.

(b) The program shall notify the subscriber of the overdue subscriber contribution payment amount and the potential for disenrollment from the program on the 10th day following the due date when the current month's premium is paid before the next month's due date. An exception to this is specified in subsection (c).

(c) When the previous month's subscriber contribution is received on the due date for the current month, a subscriber final notice will be generated on the 15th day following the due date for the current month.

(d) Subscriber contributions more than 31 calendar days overdue shall result in the subscriber and any dependents being disenrolled pursuant to Section 2698.204.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code.
Reference: Section 12735, Insurance Code

2698.407. Reinstatement

(a) A subscriber who is disenrolled for nonpayment of the subscriber contribution may be reinstated once during a rolling twelve (12) month period if the subscriber requests reinstatement within sixty (60) calendar days of the date of the disenrollment action and brings all delinquent payments up to date.

(b) A subscriber who is disenrolled more than once during a rolling twelve (12) month period for nonpayment of the subscriber contribution may only be reinstated through an appeal to the board as set forth in Section 2698.500 except as specified in subsection (c).

(c) A subscriber who has been disenrolled due to the submission of two checks which were returned for insufficient funds during a rolling twelve (12) month period will not be reinstated.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code.
Reference: Section 12735, Insurance Code

Article 5. Appeals

2698.500. Appeals to the Board

(a) Any subscriber who is dissatisfied with any action or failure to act which has occurred in connection with a participating health plan's coverage may file an appeal with the Board.

(b) In addition, the following decisions may be appealed to the Executive Director only:

(1) A program determination as to eligibility of any applicant or the applicant's dependents.

(2) A program determination to disenroll a subscriber or enrolled dependents from the program.

(3) A program determination to deny a subscriber request or to grant a participating health plan request to transfer the subscriber to a different participating health plan.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code.
Reference: Sections 12711 and 12732, Insurance Code.

2698.501. Dispute Resolution

Notwithstanding other sections in this Article, when a subscriber is dissatisfied with any action, or inaction, of the program's participating health plan in which he/she is enrolled, the subscriber shall first attempt to resolve the dispute with the participating health plan according to its established policies and procedures.

NOTE: Authority cited: Sections 12711, 12712 and 12712.5, Insurance Code.
Reference: Sections 12711 and 12732, Insurance Code.

2698.502. Filing an Appeal

(a) An appeal shall be filed in writing with the Executive Director within sixty (60) calendar days of the action or failure to act or receipt of notice of the decision being appealed.

(b) An appeal shall include all of the following:

(1) A copy of any decision being appealed; or a written statement of the action or failure to act being appealed;

(2) A statement specifically describing the issues which are disputed by the appellant;

(3) A statement of the resolution requested by the appellant; and

(4) Any other relevant information the appellant wants to include.

(c) Any appeal that does not include all necessary information shall be returned to the applicant or subscriber without review. The applicant or subscriber may re-submit the appeal. The resubmittal shall be filed within the time limits of subsection (a) or within twenty (20) calendar days of the receipt of the returned appeal, whichever is later.

NOTE: Authority cited: Sections 12711 and 12712 Insurance Code.
Reference: Sections 12711 and 12732, Insurance Code.

2698.503. Administrative Review

(a) Any appeal filed pursuant to this Article will be given an administrative review.

(b) Administrative reviews of appeals shall be conducted by the Executive Director.

(c) In conducting an administrative review of an appeal, the Executive Director may contact the appellant and/or the participating health plan for further information.

(d) The Executive Director's decision shall be in writing.

(e) If an appeal was filed pursuant to section 2698.500(a), the appellant retains the right to request an administrative hearing if the appellant is not satisfied with the decision of the Executive Director. Such a request shall be filed within thirty (30) calendar days of receipt of the Executive Director's decision. It shall include a clear and concise statement of what action is being appealed, and the reason(s) the Executive Director’s decision is not correct.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code.
Reference: Sections 12711 and 12732, Insurance Code.

2698.504. Hearings

Upon receipt of an appeal which requests an administrative hearing, the Board shall determine the appropriate forum as follows:

(a) An appeal filed pursuant to subsection (a) of Section 2698.500 shall be reviewed by the Board to determine whether it is practicable to have the hearing conducted by an Administrative Law Judge employed by the Office of Administrative Hearings pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. The Board will determine practicability by considering such issues as timing, location and costs to the parties. If it is determined to be practicable, such a hearing shall be

scheduled. If it is determined not to be practicable, the appeal shall be heard in accordance with subsection (b) of this Section.

(b) An appeal filed pursuant to subsection (a) of Section 2698.500 but which it has been determined by the Board should be heard in accordance with this subsection, shall be heard according to the appeal procedures, including pre- and post-hearing procedures, set forth in Chapter 2.5 (commencing with section 251) of Division 2 of Title 1 of the California Code of Regulations. Chapter 2.5, as adopted on June 4, 1984, is hereby incorporated by reference, subject to the following modifications:

(1) Reference to the Health and Welfare Agency or the component department shall be deemed reference to the Managed Risk Medical Insurance Board.

(2) Reference to the private non-private human service organization shall be deemed reference to the petitioner.

(3) Reference to the grievance procedure established in accordance with Health and Safety Code section 38036 shall be deemed reference to the administrative review process set forth in section 2698.503.

(4) Reference to Health and Safety Code sections providing the bases, grounds, authorization or procedures for appeals shall be deemed reference to the bases and authorization for appeal found in section 2698.500, and the appeal procedures found in this section.

(5) The 30-day time period specified in section 251(b) shall be extended to 60 days, and the 10-day time period in section 252(a) shall be extended to 30 days.

(6) If the proposed decision submitted to the Board is not adopted as the decision, the Board may itself decide the case on the record, or may refer the case to the same hearing officer to take additional evidence. If the case is referred back to the hearing officer, the hearing officer shall prepare a new proposed decision based on the additional evidence and the record of the prior hearing.

(7) The decision of the Board shall be issued within 90 days following the initial hearing or, if the case is referred back to the hearing officer, within 90 days of the second hearing.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code.
Reference: Sections 12711 and 12732, Insurance Code.